

MOUNTAIN ACUPUNCTURE CLINIC DISCLOSURE STATEMENT

Education and Experience

Tyler Abby Stroebel earned her Masters of Acupuncture and Oriental Medicine degree from Emperor's College of Traditional Oriental Medicine in California, December 26, 2001. This four- year program consisted of 3,050 hours of education including 1,000 hours of clinical practice. The National Certification Commission certified her as a Diplomate in Acupuncture and Traditional Chinese Medicine for Acupuncture and Oriental Medicine (NCCAOM) in November 2001. This includes certification in Clean Needle Technique. She was licensed in the state of California to practice acupuncture and Chinese herbology on June 24, 2002.

Tyler's training includes adjunctive therapies such as herbal medicine, moxibustion, tui na, acupressure, cupping, bloodletting, gwa sha, auriculotherapy, and dietary and lifestyle recommendations.

Tyler is a member of the Acupuncture Association of Colorado. She is a registered acupuncturist in Colorado and a licensed acupuncturist in California. None of these licenses, certificates, or registrations has ever been suspended or revoked.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Fee Schedule and Cancellation Policy

Adult Visit	\$100.00
Child Visit (0-10)	\$60.00

Pre-payment packages:

7 Treatment Package (\$5 off each treatment-never expires)-\$665.00
10 Treatment Package (\$10 off each treatment-never expires)-\$900.00
Kid Package (7 treatments) (\$5 off each treatment-never expires)-\$385

Please cancel your appointment 24 hours in advance to avoid being charged for that time.

Patients Rights

- The patient is entitled to receive information about the methods of therapy, the techniques, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The Director of Registrations, Colorado, Department of Regulatory Agencies, regulates the practice of acupuncture. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite1340, Denver, Colorado 80202. Telephone (303) 894-7851.

Consent

I give my consent to receive treatment at Mountain Acupuncture Clinic LLC. I understand that payment is due at the time that services are rendered. I understand I may be charged for any appointments I miss if I do not give 24 hours cancellation notice. I have been informed of the policies by which my information is used and transmitted. I hereby authorize the release of any medical records or other information necessary to process my claim. I also authorize payment of medical to benefits Mountain Acupuncture Clinic LLC services rendered. I agree to pay all deductibles and co-pays, which my insurance deems to be my responsibility; at the time services are rendered. **I further agree that should the amount paid by my insurance be insufficient to cover the entire medical expense or benefits are not remitted by my insurance company within 60 days, I will be responsible to Mountain Acupuncture Clinic LLC for payment of the entire balance. If, also, my insurance remits payment to me instead of Tyler Stroebel L.Ac or Mountain Acupuncture Clinic LLC, I will sign over such checks within 5 days of receipt unless other arrangements have been made.**

I have read and understand this document.

Patient's Signature

Date

Guardian's Signature

Date

NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Mountain Acupuncture Clinic LLC uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Mountain Acupuncture Clinic LLC will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Mountain Acupuncture Clinic LLC may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Mountain Acupuncture Clinic LLC may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. You have a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer Diva Olvera and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Mountain Acupuncture Clinic LLC must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints please contact Tyler Stroebel at 720-201-3817.

Patient Signature

Date

-PERSONAL HISTORY-

Name _____ Weight _____ lbs. Height _____ ft. _____ in

1. Operations (indicate year):

Tonsils _____ Appendix _____ Gall Bladder _____ Thyroid _____ Hemorrhoids _____
Stomach _____ Hernia _____ Breast _____ Uterus _____ Varicose Veins _____ Prostate _____
Other _____

2. Medical Illnesses (indicate year first diagnosed):

Anemia _____	Gall Bladder Disease _____	Kidney Disease _____
Arthritis _____	Gout _____	Liver Disease _____
Asthma _____	Heart Attack _____	Lung Disease _____
Bleeding Disorder _____	Heart Disease _____	Overweight _____
Blood Clot _____	High Blood Pressure _____	Stroke _____
Cancer _____	Hyperthyroidism _____	Tuberculosis _____
Diabetes _____	Hepatitis _____	Ulcer _____
Emotional Problems _____	Hypothyroidism _____	Other _____

3. Injuries (list type of injury and year. Example: concussion-'76, knee-'85):

4. Habits (include type, amount per day and number of years with that habit. Example: cigarettes- 1pack/day-11yrs):

Tobacco: _____
Alcohol: _____
Caffeine (i.e. coffee, tea, cola): _____
Chocolate, cocoa: _____ Drugs: _____
Other: _____

5. Allergies (list type [i.e. pollen, dairy products] and date started):

Allergic to _____ from _____ Allergic to _____ from _____
Allergic to _____ from _____ Allergic to _____ from _____
Allergic to the following medications (please list reactions): _____

-PERSONAL HISTORY-

Name _____ Date _____

Please put a check next to the symptom(s) that you have experienced.

General Symptoms:

- | | | |
|--|--|--|
| <input type="checkbox"/> Lack of appetite | <input type="checkbox"/> Tendency to catch colds | <input type="checkbox"/> Tendency to become "obsessive" |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Nasal problems | <input type="checkbox"/> Decreased sex drive |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Loose stools (diarrhea) | <input type="checkbox"/> Knee problems | <input type="checkbox"/> Ear ringing, tinnitus |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Sudden weight loss |
| <input type="checkbox"/> Belching or burping | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Difficult to stop bleeding |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hay fever | <input type="checkbox"/> High cholesterol levels |
| <input type="checkbox"/> Feeling of retention of food in stomach | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Feeling of claustrophobia |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Allergies | <input type="checkbox"/> Faint easily |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Decreased sense of smell |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Edema | <input type="checkbox"/> Intolerance to weather changes |
| <input type="checkbox"/> Sciatica pain | <input type="checkbox"/> Colitis | <input type="checkbox"/> Soft or brittle nails |
| <input type="checkbox"/> Gall stones | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Difficulty in making plans or decisions |
| <input type="checkbox"/> Difficulty digesting oily foods | <input type="checkbox"/> Constipation | <input type="checkbox"/> Easily angered or agitated |
| <input type="checkbox"/> Black "tar-like" stools | <input type="checkbox"/> Mentally "restless" | <input type="checkbox"/> Recent use of antibiotics |
| <input type="checkbox"/> Light-colored stools | <input type="checkbox"/> Laughing for no apparent reason | <input type="checkbox"/> Spasm or twitching of muscles |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Insomnia | |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hair loss | |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Kidney stones | |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bronchitis | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing impairment | |
| <input type="checkbox"/> Headaches specific location | <input type="checkbox"/> Eye problems | |
| _____ | <input type="checkbox"/> Angina pectoris | |

-PERSONAL HISTORY-

Name _____ Date _____

Please put a check next to the symptom(s) that you have experienced.

Allergies:

- Runny or stuffy nose
- Itchy nose or ears
- Sneezing
- Sinus Pressure
- Headache
- Eyes: Red Water Itchy (please circle)
- Wheezing
- Coughing
- Wheezing or Coughing with Exercise
- Skin Problems
- Hives
- Swelling
- Recurrent/Frequent Infections
- Reaction to insects
- Asthma
- Hay Fever

For Men:

- Prostate problems
- Painful or burning urination
- Pain or coldness in the genital area

For Women:

- Premenstrual pain or menstrual pain
 - Irregular menses
 - Swelling/pain of breast
- Are you pregnant? yes no